

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5565HIC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/28/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LARRY'S GROUP HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6643 LILAC SKY AVE</b> <b>LAS VEGAS, NV 89142</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of a State Licensure Complaint Investigation conducted on your facility 1/26/11 through 2/28/11. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The census at the time of the survey was one. One resident file was reviewed and one employee file was reviewed.</p> <p>Complaint #NVS00027463 -the allegation regarding medication was substantiated. See Tag 0017.</p>	H 000		
H 017	<p>Director Duties-Protective Supervision</p> <p>NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 3. Ensure that the residents of the home: (b) Receive: (3) Protective supervision and adequate services to maintain and enhance their physical, mental and emotional well-being.</p> <p>This Regulation is not met as evidenced by: Based on record review, observation and interview from 1/26/11 through 2/28/11, the director failed to ensure that 1 of 1 residents</p>	H 017		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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H 017	Continued From page 1  received protective supervision and adequate services to maintain and enhance their physical, mental and emotional well-being (Resident #1 -received an incorrect dosage of prescribed medication Hydrocodone).	H 017			

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